

**Massachusetts Department of Public Health
Community Sanitation Program
Recreational Camp Injury Report Form**

In accordance with M.G.L. c. 111, §§ 3 and 127A and 105 CMR 430.000: Minimum Sanitation and Safety Standards for Recreational Camps for Children (State Sanitary Code Chapter IV), 105 CMR 430.154 specifically requires that a report be completed, on a form prescribed by the Massachusetts Department of Public Health, for each fatality or serious injury as a result of which a camper or staff person is sent home, or is brought to the hospital or a physician's office and where a positive diagnosis is made. Such injuries shall include, but shall not necessarily be limited to, those where suturing or resuscitation is required, bones are broken, or the child is admitted to the hospital. **A copy of each injury report must be sent to the Massachusetts Department of Public Health within SEVEN (7) days of the occurrence of the injury.**

PLEASE PROVIDE A COMPREHENSIVE AND THOROUGH RESPONSE TO EVERY QUESTION.

1. Name of Camp: _____
2. Street Address (please indicate the camp's in-session, physical address):

City/Town: _____ Zip Code: _____
3. Name of Camp Director: _____ 4. Telephone: _____
5. Name of Person Completing Form: _____
6. Today's Date: _____ 7. Date of injury: _____ 8. Time of Injury: _____ ☐ AM ☐ PM
9. Enter the number of campers and staff who were injured: ___ Camper ___ Staff member

Note: Fill out a separate form for each injured person

10. a) Age of person whose injury is described on this form: _____ b) Gender: ☐ M ☐ F
11. Where did the injury occur? ☐ On camp property ☐ Off camp property
12. Please specify the type of facility where the injury occurred:

<input type="checkbox"/> Athletic or recreational facility	<input type="checkbox"/> Pool
<input type="checkbox"/> Dorm or sleeping quarters	<input type="checkbox"/> Other water body (not pool)
<input type="checkbox"/> Motor vehicle	<input type="checkbox"/> Other, please specify: _____
13. What was the incident outcome? Please check all that apply:
☐ Injury ☐ Illness ☐ Death
14. Explain in detail how the injury occurred (e.g. what type of activity was the injured person engaged in when the injury occurred) and describe the nature of the injury. **Do not include names or other personal identifying information regarding the injured person or other involved parties.**

Report ID # (internal use only): ____ - ____ - ____
Cross-reference # (internal use only): ____ - ____ - ____

(continued over)
Revised October 2014

15. Type of injury. Please check all that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alleged abuse or neglect | <input type="checkbox"/> Allergic reaction | <input type="checkbox"/> Bite or sting | <input type="checkbox"/> Bruise or contusion |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Concussion | <input type="checkbox"/> Cut or laceration | <input type="checkbox"/> Drowning |
| <input type="checkbox"/> Fracture or dislocation | <input type="checkbox"/> Heat or cold (e.g., heat exhaustion, hypothermia) | <input type="checkbox"/> Muscle strain | <input type="checkbox"/> Near drowning |
| <input type="checkbox"/> Psychological or mental health issue | <input type="checkbox"/> Undetermined | <input type="checkbox"/> Viral or bacterial infection | |
| <input type="checkbox"/> Other, please specify: _____ | | | |

16. What body part(s) were injured? Please check all that apply:

- | | | | | | |
|---|----------------------------------|----------------------------------|--------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Head, neck, and/or face | | | | | |
| <input type="checkbox"/> Torso, please specify: | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Back | <input type="checkbox"/> Chest | <input type="checkbox"/> Hip | |
| <input type="checkbox"/> Upper extremity, please specify: | <input type="checkbox"/> Arm | <input type="checkbox"/> Fingers | <input type="checkbox"/> Hand | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Lower extremity, please specify: | <input type="checkbox"/> Ankle | <input type="checkbox"/> Foot | <input type="checkbox"/> Knee | <input type="checkbox"/> Legs | <input type="checkbox"/> Toes |
| <input type="checkbox"/> Internal | | | | | |
| <input type="checkbox"/> Other, please specify: _____ | | | | | |

17. Where was the person treated? Please check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Admitted to hospital | <input type="checkbox"/> Off-site medical facility (e.g., emergency room, physician's or dentist's office) | <input type="checkbox"/> On-site medical facility (e.g., clinic or infirmary) |
| <input type="checkbox"/> Other, please specify: _____ | | |

18. Was injured person sent home? ☐ Yes ☐ No

19. Did your camp change equipment, policies, or procedures as a result of this incident? ☐ Yes ☐ No

20. If yes, please check all that apply:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Activity removed or forbidden | <input type="checkbox"/> Changes to equipment implemented | <input type="checkbox"/> New safety procedures implemented | <input type="checkbox"/> Safety education updated |
| <input type="checkbox"/> Venue changed or altered <input type="checkbox"/> Other, please specify: _____ | | | |

21. Briefly explain changes implemented as a result of this incident. If no changes were made, please explain why not.

PLEASE MAIL, FAX, OR EMAIL CAMP INJURY REPORTS TO:

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
BUREAU OF ENVIRONMENTAL HEALTH
COMMUNITY SANITATION PROGRAM
250 WASHINGTON STREET-7th FLOOR
BOSTON, MA 02108-4619
TELEPHONE (617)-624-5757 FAX (617) 624-5777
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